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ABSTRACT

This guide is designed to help readers understand depression and factors related to its onset in later life; recognize signs of depression and potential suicide; and know actions they can take if they suspect an older family member or friend may be depressed or contemplating suicide. Following a brief introduction, a chapter on depression discusses the severity of depression, explains how depression differs from grief, and examines types of depressive disorders. The next section examines what triggers depression. It considers a variety of factors, including heredity, biochemical changes, drugs, illness, personality, sensory loss, stress, and seasonal changes. A section on recognizing the signs of depression discusses age-related changes, denial, atypical signs, and physical illness. The next section offers advice to readers who want to help the depressed older person. A section on treatments for depression discusses medication therapy, psychotherapy, and electroconvulsive therapy. A section on handling special problems describes what to do if the person denies being depressed, explains how a person can help from a distance, and instructs readers in how to identify and respond to a suicidal person. The document concludes with a section on myths and facts about depression and suicide, a final note on depression, and a list of publications for further reading on the subject of depression. (NB)

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DEPRESSION IN LATER LIFE

RECOGNITION AND TREATMENT



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Albert is 78. Two years ago his wife of 54 years died. Shortly thereafter, his closest friend also died. Since then he has become increasingly forgetful and disinterested in family activities. His children are concerned that "father has become senile."

Mrs. Jensen, 74, has always been active socially. In the last few months she's withdrawn into her home, isolating herself from family and friends. The easiest chore seems impossible. Former pleasurable activities are no longer enjoyable. She's tired much of the time, but has difficulty sleeping. Her daughter says, "I feel like a big black cloud is hanging over Mother. I've asked if she's depressed, but she says no. I don't know what to do."

Mr. Jones' life revolved around his work. Since retiring eight months ago, he feels lost and useless. He's neglecting his appearance, and drinking more.

Martha, 82, says, "My family would be better off without me." Although she is mentally alert, severe crippling arthritis means she must depend on others for assistance. She's always prided herself on being able to do for herself. Lately she's agitated much of the time and hostile toward family and friends. Her daughter often finds her still in bed at noon.

DEPRESSION IN LATER LIFE

RECOGNITION AND TREATMENT

For Albert, Mrs. Jensen, Mr. Jones, and Martha, life has lost its joy. They are suffering from depression. They may not recognize the symptoms of an underlying depression, may fear being labeled "crazy" or "weak" and therefore not seek help, or may be too depressed to take action, lacking the energy to do so.

Depression is disabling. It can cause physical problems and it can disrupt a marriage and a family. Living with a depressed person is not easy because depressed people tend to turn inward, not think about others, and sometimes become hostile. Family and friends sometimes feel as though they are being driven away.

When depression is severe, it can be life-threatening. Health can fail rapidly. In fact, depressed people appear to be more susceptible to infection and other illnesses, and their recovery from illness takes longer than for non-depressed people.

Most people who commit suicide are depressed. Suicide is disturbingly common in the older population. Males over the age of 65 have the highest rate of suicide, three to four times greater than in the general population.

Recognizing the symptoms of depression is the first critical step in helping the depressed person. Unfortunately, depression often goes unrecognized. In older people, depression is frequently misdiagnosed or considered to be a natural part of aging. Sometimes people expect that "to be old is to be depressed." Depression is not inevitable, nor is it normal in late life.

Depression also is highly treatable. Over 80 percent of depressed people can be treated effectively and their symptoms alleviated within weeks. However, many depressed people never receive proper treatment, and undertreatment is a common problem. Without treatment, depression can last for weeks, months, or even years. The tragedy is not depression itself. Rather, the tragedy is ignored, undiagnosed, or untreated depression. People do not need to suffer its debilitating effects.

This publication is designed to help you understand depression and factors related to its onset in later life; recognize signs of depression and potential suicide; and know actions you can take if you suspect an older family member or friend may be depressed or contemplating suicide.



WHAT IS DEPRESSION?

SEVERITY OF DEPRESSION

HOW DEPRESSION DIFFERS FROM GRIEF

TYPES OF DEPRESSIVE DISORDERS

When faced with the challenge of helping a depressed person, it's important first to understand depression yourself. As you begin to understand what depression is and is not, you will be better able to respond in helpful and caring ways.

Depression is one of the most common emotional disorders. It can occur in anyone— young or old, male or female, rich or poor. The term "depression" is used to describe a range of conditions, from a simple mood to severe depression. Regardless, sadness is a predominant feeling. Occasional feelings of unhappiness, feeling "down," or being in a "blue" mood are normal. But when the feeling goes beyond normal mood swings and adversely affects one's life, the problem is depression, an illness.

SEVERITY OF DEPRESSION

There are many ways to describe depression. One way is by its severity. Although mild depression is the most common, it also requires our attention because even a mild depression can deepen or persist.

Mild depression is a brief, temporary sadness that is a normal reaction to stress, tension, frustration, and disappointment. It does not seriously interfere with functioning or daily activities. Professional treatment may not be needed. Instead, emotional support and an opportunity to talk, or a change of pace or situation may be all that is needed.

A moderate depression is more intense and lasts longer. It is usually caused by a loss or an upsetting event. For the moderately depressed person, daily activities become harder but he still meets daily responsibilities. Professional help may be necessary.

A severely depressed person shows marked behavior changes and loss of interest in the outside world. Often a chemical imbalance is involved. His ability to function is impaired and he is unable to cope. Professional treatment is necessary.

How Depression Differs from Grief

It can sometimes be difficult to differentiate depression from grief. For example, both depressed and grieving people report experiencing sadness, tearfulness, sleep problems, and appetite and weight changes. However, there are differences. It's important to understand these differences so that you can better recognize when a person may be depressed versus grieving and offer the most appropriate support.

Characteristics of depression. Depression may not have a specific trigger. Also, depressed people tend to be passive, remaining "stuck" in sadness for a long time. They have generalized feelings of helplessness, hopelessness, pessimism, and emptiness. They lack interest in previously enjoyed activities.

It is common for a depressed person to have low self-esteem and self-confidence; he usually feels like a failure, unattractive, and unloved. He is likely to be unresponsive and humorless, incapable of being happy or even temporarily cheered up. He is likely to resist help and support.

Depressed people have difficulty identifying or describing their feelings. They tend to cry for no apparent reason, but crying does not bring relief. Inappropriate or excessive guilt is common. A person may dwell on past failures.

Characteristics of grief. Grief is more likely to occur as a result of a significant loss or multiple losses. Grief is active; the person gradually progresses through the sadness toward recovery.

A grieving person feels emotional pain and emptiness related to a specific loss. He usually can be persuaded to participate in activities, particularly as he begins to heal. Self-esteem usually remains intact; he does not feel like a failure, although there may be such feelings



related to the specific loss.

A person suffering from grief will sometimes be able to laugh and enjoy humor. He is more likely to accept support. He experiences a range of emotions; generally these are intense.

Grieving people cry for an identifiable loss, and crying provides relief. They are not likely to be suicidal. Any self-blame and guilt they feel relate directly to the loss, are episodic, and resolve as they progress toward healing.

Sometimes grief evolves into a serious depression, particularly when the grief process is blocked or mourning over a loss is increasingly turned inward. Sadness for weeks, even months, after a loss or unwanted change is to be expected. But when intense sadness continues, when the person becomes "stuck" in sadness, or when he is increasingly unable to function on a daily basis, the bereavement has turned into depression. When thoughts of self-blame associated with a loss, for example, the "I should have's" common with the death of a loved one, become excessive or prolonged (last longer than six months), chances are the bereavement has become complicated by depression.

TYPES OF DEPRESSIVE DISORDERS

Depressive disorders come in different forms, with three of the most common types known as major depression, dysthymic disorder, and bipolar disorder.

Major depression differs from the normal "down mood" in several ways. A major depression is pervasive, persistent, and intense. It interferes with normal social and physical functioning. The person is not simply sad. Rather, he experiences an exaggerated sadness coupled with pessimism—he feels the sadness will persist indefinitely regardless of what might be done. There is a loss of pleasure in life.

One woman described her depression as, *"I felt like I was walking around in wet cement that kept getting harder and harder."* Another said, *"While depressed, I felt like I was in the middle of a black cloud that was getting blacker. I lost all feeling. I just didn't care about anything or anyone."*

Some people who experience a major depression have only one or two episodes in a lifetime. Others have recurrent episodes and require ongoing medication.

Dysthymic disorder. This is a form of depression in which the person is chronically depressed—depressed 2 years or longer without a break in the depression of at least 2 months. The symptoms tend to be less severe than with a major depression, but can keep the person from feeling well and functioning effectively. Without adequate treatment, depression is more likely to become chronic.

Bipolar disorder. This condition involves emotions at two extremes or poles with the person going from deep, depressive "lows" to extreme manic "highs." It's also frequently referred to as manic depression. In the depressive phase, the individual suffers from symptoms typically associated with depression.

During the manic phase, the person experiences a marked increase in energy, extreme insomnia, elation, and increased irritability. Mania often affects thinking, judgement, and social behaviors. For example, a person in a manic phase may make unwise financial decisions, spending money he does not have. Late onset of a bipolar disorder is rare, but manic-depressives do grow old.



WHAT TRIGGERS DEPRESSION?

HEREDITY
BIOCHEMICAL CHANGES
DRUGS
ILLNESS
PERSONALITY
SENSORY LOSS
STRESS
SEASONS

People get depressed for different reasons. There may be one factor or many. Understanding the cause is important since it will determine the most appropriate help. You will be better able to assist a depressed person, or even prevent depression, if you learn to recognize factors which can put an older person at risk for depression. Some of the following are common to people of all ages; others are more frequent in later life.



HEREDITY

Studies show that some depressive disorders, particularly bipolar disorder, are hereditary. Genetic factors, however, usually do not show themselves for the first time in late life.

BIOCHEMICAL CHANGES

A proper balance of brain chemicals is necessary to maintain normal mood. An imbalance of certain brain chemicals, particularly neurotransmitters which are necessary for communication

between the brain's nerve cells, are associated with depression.

DRUGS

Depression can be a side effect of many medications. Among these are high blood pressure medication, sedatives, tranquilizers, and anti-Parkinson and anti-inflammatory drugs. A depression may develop immediately or may not show up for months after starting a medication.

Because alcohol is a central nervous system depressant, it can cause depression or intensify an existing depression. Some depressed people turn to alcohol for relief, but it may mask the symptoms of depression.

ILLNESS

Some medical conditions can actually cause depression. These include thyroid disease, pernicious anemia, brain tumor, Parkinson's disease, cancer (particularly cancer of the pancreas), uremia or kidney disease, and electrolyte imbalance. Sometimes depression is the first symptom of an undiagnosed medical problem.

Depression often is a reaction to illness, especially one that produces chronic pain, disability and dependence. Medical conditions associated with changes in body image (strokes, amputations, and problems in walking that require assistive devices) are particularly threatening. Those that provoke greater anticipation of loss of function, disability, or death (such as cancer, Alzheimer's disease, or cardiovascular disease) also can bring on depression. People who pride themselves on being independent and self-reliant may be particularly susceptible to depression when illness means increased dependence on others.

PERSONALITY

People who have low self-esteem, are highly self-critical, consistently pessimistic, unusually passive and dependent, or easily overwhelmed by stress tend to be more prone to depression. They usually suffer from low self-esteem.

People who are highly resourceful are less likely to become depressed than those with low levels of resourcefulness. And, if they do get depressed, they are more likely to recover quickly and are less likely to have a relapse.

SENSORY LOSS

Loss of sight and hearing can trigger depression. These changes not only can affect a person's ability to function in the physical environment, but also isolate him and make him more dependent. Even a slight hearing loss, for example, can be emotionally upsetting if it interferes with correctly understanding others. Many people withdraw from group interaction when it becomes difficult to hear.

STRESS

Living in a highly stressful situation over time, such as taking care of a spouse with dementia, living in poverty, or experiencing declining health, can cause depression. Inability to adjust to a major life change—death of a spouse, divorce, death of an adult child, chronic illness, retirement, a forced move from one's home—can precipitate depression.

The later years are often a time of loss. As one older person said, *"The older I become, the more goodbyes I have to say as older friends and relatives die one by one."* Older people also are more prone to multiple losses occurring in rapid succession. And sometimes their support networks are fragile or non-existent.

Perceived loss of control often leads to depression. People who are unable to control significant life events, or believe their actions make no difference, may develop a sense of helplessness. A person who feels both helpless and hopeless is at greater risk of suicide.

SEASONS

Research shows that the short days of winter, particularly in rainy, cloudy regions, can trigger a low-energy type of depression in susceptible individuals. This condition, called seasonal affective disorder (SAD), is an extreme form of the "winter blahs."



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RECOGNIZING THE SIGNS OF DEPRESSION

AGE-RELATED CHANGES

DENIAL

ATYPICAL SIGNS

PHYSICAL ILLNESS

Despite its many symptoms, depression often goes unnoticed. Here's why depression can be more challenging to recognize in older people.

AGE-RELATED CHANGES

Signs of depression sometimes look like normal age-related changes. Stooped posture, reduced physical activity, increased sleep problems, and loss of appetite (caused by a decline in taste sensation) are experienced by many older people who are not depressed.

DENIAL

Older people tend to deny being depressed. Many grew up in an era when people did not talk about feelings, but "toughed things out." They feel that to be depressed is a sign that they're "weak" or "crazy." You need to observe a person's appearance and behavior, rather than relying on what she says.

ATYPICAL SIGNS

Depression may be dominated by moods other than sadness, such as agitation, irritability, or anxiety. The person may be constantly complaining, pacing, and easily angered. Paranoia and suspiciousness are also more common. Sometimes depression is expressed through hostile behavior. This is particularly important to recognize because such behavior can alienate family members and interfere with helpful assistance. One daughter said, *"I remember my mother behaving in a hostile manner to her grandchildren whom she once loved dearly. She was more likely to exhibit that behavior than to complain about feeling depressed."*

Older depressed people frequently report

memory problems that are greatly out of proportion to reality. Some depressed older people will appear more confused than depressed. A common mistake in diagnosing depression in the elderly is to confuse it with dementia (memory loss or impairment in mental functioning as a result of changes in the brain).

Older people are more likely to express emotional distress in terms of bodily symptoms. Vague complaints of aches and pains (for example, *"I feel like I don't have any blood"; "My body just feels heavy and weak"*), unfounded fears about a serious illness, or complaints about health problems for which there is no medical basis can signal an underlying depression.

PHYSICAL ILLNESS

Physical illness can mask depression and depression can mimic physical illness. Many physical illnesses have symptoms similar to those produced by depression, for example, weakness, fatigue, social withdrawal, and appetite changes. This can sometimes lead to a misdiagnosis of a physical illness when depression is the problem. When depression coexists with an illness and goes untreated, it can worsen or complicate the medical problem.

Remember, you don't need to make the diagnosis of depression yourself. But you need to be aware of common signs and know how to locate and use available health care resources.

There is no single sign that identifies depression. Rather, it is determined by a cluster of symptoms. A serious depression affects the entire person: physical well-being, feelings, thoughts, and behavior. The main features are a persistent sadness for at least 2 weeks and a change in usual patterns, behavior, and mood. For example, the once socially active woman becomes reclusive; the man who has always taken pride in his appearance dresses slovenly. The person also must experience several of the signs given below. If you are wondering whether someone you know is seriously depressed, check the following lists for signs you have observed.

Physical Signs

- ☐ Aches, pains, or other physical complaints that seem to have no physical basis
- ☐ Marked change in appetite (or weight loss or gain)
- ☐ Change in sleep patterns (insomnia, early morning waking, sleeps more than usual)
- ☐ Fatigue, lack of energy, being "slowed down"

Emotional Signs

- ☐ Pervasive sadness, anxiety, or "empty" mood
- ☐ Apathy (lack of feeling)
- ☐ Decreased pleasure or enjoyment
- ☐ Crying for no apparent reason
- ☐ Indifference to others

Changes in Thoughts

- ☐ Feelings of hopelessness, pessimism
- ☐ Feelings of worthlessness, self-reproach, inadequacy, helplessness
- ☐ Inappropriate or excessive guilt
- ☐ Impaired concentration, slowed or disorganized thinking
- ☐ Forgetfulness; problems with memory
- ☐ Indecisive; unable to make decisions or take action
- ☐ Recurrent thoughts of death or suicide

Changes in Behavior

- ☐ Loss of interest or pleasure in previously enjoyed activities, including sex
- ☐ Neglect of personal appearance, hygiene, home, and responsibilities
- ☐ Difficulty performing daily tasks; ordinary tasks are overwhelming
- ☐ Withdrawal from people and usual activities; wanting to be alone
- ☐ Increased use of alcohol and drugs
- ☐ Increased irritability, argumentativeness, or hostility
- ☐ Greater agitation, pacing, restlessness, hand wringing
- ☐ Suicide attempts or talking about suicide

The more signs you have checked, the more likely the person is suffering from a serious depression and may need your assistance in seeking proper help.

If several of these symptoms have been present for two weeks or longer, or if the person's day-to-day functioning has been affected, get an evaluation by a professional.

You may also find some clues indicating a person is depressed if you listen carefully to what he or she says. Verbal statements such as the following are often associated with depression and suicide:

- *I just feel down in the dumps.*
- *Nobody cares.*
- *No matter what I do, I can't do anything right.*
- *I just don't feel like doing anything.*
- *No one wants a dreary old woman around.*
- *My life is worthless.*
- *I'm tired of living.*
- *What's the use of living?*
- *My family would be better off without me.*
- *There's nothing to live for anymore.*
- *I feel like an empty shell.*

As with other signs of depression, it's important to compare such statements with the way the person typically has behaved in the past. If she previously has been satisfied with life, she may be seriously depressed. Coming from someone who always has been pessimistic and negative, these phrases may not be as significant. However, consider the possibility that the person has been depressed for a long time. Sometimes depression can develop so slowly as to seem natural. Without treatment, a depression can continue for months or even years.





HELPING THE DEPRESSED PERSON

ENCOURAGE TREATMENT
GET EXPERT HELP
SEEK HELP FOR YOURSELF
LISTEN AND VALIDATE FEELINGS
BUILD A SUPPORTIVE ENVIRONMENT
STRUCTURE ACTIVITY
GIVE THE PERSON CONTROL
LEARN ABOUT MEDICATIONS
BE ALERT TO SIGNS OF SUICIDE
BE WATCHFUL AT HOLIDAYS

The earlier the depressed person receives help, the sooner the symptoms will be alleviated and the speedier the recovery. As a family member or friend, you play a critical role in helping him return to full functioning. However, there is a fine line between "helping" people to get well and "enabling" them to remain depressed. Sometimes helpers unknowingly reinforce depression; for example, if attention is given primarily to the person when he is depressed or complaining. You need to be careful that the help you give is not rewarding depressive, dependent behavior. Consider the following guidelines as you reach out to help.

ENCOURAGE TREATMENT

One of the most important things you can do is encourage the depressed person to get treatment. Expect to take an active role in getting help for him. The low energy and helpless feelings of depression can keep the person from taking the initiative. Recognize, too, that the older person may have been socialized to view depression and seeking help as a sign of weakness or personal failure, and therefore may deny being depressed or may resist help.

Don't force the person into treatment or threaten to institutionalize him. Helping someone overcome depression should be positive, healing, and designed to return him to normal functioning. It should never be held over him as a threat or punishment. In talking with him, it's important to communicate your concern and caring and to give hope. For example, you might say, *"Dad, I love you and I am concerned about you. In the last month I have seen you increasingly lose weight. John also told me you*

are no longer going out with the group. Your weekly bowling game has always been so important to you. I know this has been a difficult time, but there is help available that can help you feel better."

Avoid putting yourself in a power struggle with the person who refuses help. He has a right to remain depressed even though it is uncomfortable for you, as well as him. Only when the person's life is in danger should you intervene without permission.

GET EXPERT HELP

When someone close to you is depressed, remember you don't need to solve the problem all by yourself. Your best strategy is to locate and use the resources available to you.

When to get help. It's better to seek help early than wait for a crisis. It will be less stressful for both you and the older person. Here are some signs that professional help is necessary:

- You're wondering if it's time for professional assistance. This usually means it is time.
- The depressive symptoms persist for more than 2 weeks.
- Depression is interfering with the older person's daily functioning and activities.
- The person's health is threatened by the depression.
- You observe signs of potential suicide.
- What you have done doesn't seem to be working and you don't know what else to do.
- You find yourself getting pulled down by the person's depression.

The availability of mental health services varies by community. If the person lives in a rural area, you may need to take him to a larger city for evaluation and development of a treatment plan.

Whenever possible, consult with a professional experienced with the elderly. Most important, select a professional who is knowledgeable about mental health issues in later life and believes older people can recover from depression. Ask specifically if the professional

has a background or training in geriatrics or mental health issues and aging. If a geriatric specialist is available in the older person's community, that's usually a good place to start. Find out whether Medicare will pay for the professional's services.

Here are some additional resources you might contact for assistance:

- **The older person's physician.** Whenever depression is suspected, one of your first steps should be to arrange for your family member or friend to have a complete physical examination to uncover any physical illnesses or medications that may be contributing to the depression. Go with him or call the doctor beforehand to explain your perspective on the situation. You need to be assertive and let the doctor know the changes you have observed. If physical illness is ruled out, seek a competent mental health professional for evaluation and treatment. Ask the doctor for a referral.
- **Community mental health center.** Some centers provide a broad range of professional mental health services, including crisis intervention, at a reasonable cost. Services are provided on a sliding fee scale, where charges are based on ability to pay. Some mental health centers provide outreach programs through senior centers.
- **Private mental health professionals.** This group includes psychiatrists, medical doctors who specialize in mental health treatments and can prescribe medications; psychologists, people who hold Ph.D's in psychology and specialize in psychological testing and therapy; and other mental health specialists (for example, psychiatric nurses, individual and family therapists, and social workers) who have specialized training in counseling and helping people cope with their problems.
- **Local and state hospital geriatric programs.** Hospital geriatric programs provide in-patient diagnostic work-ups and treatment.
- **Clergy trained in counseling.** Many clergy have been trained in counseling techniques.

If the older person has been active in a church or synagogue, he may be more receptive to help from this source.

- **Area agencies on aging.** Your local area agency on aging may be able to provide you with a list of agencies and professionals specializing in geriatric mental health problems.

SEEK HELP FOR YOURSELF

Because dealing with a depressed person can be frustrating, you may benefit from professional help. It's important to take care of yourself and not let the depressed person's behavior "get to you" or "drag you down." As one daughter said, *"I didn't know who was being affected more by Mom's depression. Mom or me. After every visit I was a wreck. It seemed that nothing I did made a difference for her. And I'd end up feeling depressed!"*

A mental health specialist can help you to better understand depression, to deal with frustrations and negative feelings you may have about the depressed person's behavior, and to learn what your role should be in speeding his recovery. Your seeking help may also serve as a "bridge" to get a resistant person to accept professional help.

LISTEN AND VALIDATE FEELINGS

A person who is depressed needs to be listened to and understood. As one person said, *"The opportunity to talk helps to get the sad out of you."* Ask what is happening in the person's life and then really listen. Give the person a chance to talk about his feelings. Acknowledge the difficult situation(s) he has experienced and the "hurt" he may feel:

- *Dad, you've been through so much in the last few months with the company cutting your position and your not being able to find another job. This must be painful for you. I know how important your work always has been to you. If this had happened to me, I would feel as though I had been stabbed with a knife and it's twisting deeper and deeper. I'd be angry, wondering how the company*

could do this to me after I'd worked faithfully for 34 years. Is this somewhat how you're feeling?

- *I know that the move from your home to living in one room probably has been very difficult and filled with sadness. There must be many special memories associated with your home and a lot of things you have had to give up. What has been most difficult for you?*

Allow repressed anger and despair to be expressed. By listening you show concern and openness, and it's likely you will be told more.

Older people experience many losses, some permanent, which can cause depression. Allow the person to move through the grief process at his own pace. If you rush him, he may stall and become "stuck" in the middle of the process.

Look beyond the loss itself to the meaning the person attaches to it. For example, a move from one's home to a care facility may be interpreted as "I'm no longer useful," or "My family doesn't love me." Or the person may feel a total loss of control or see only more sadness in the future.

Don't try to talk the person out of his feelings. It will only make him feel worse if you try to get him to cheer up or quit thinking about problems. Avoid moralizing, telling him to try harder to get well, or pressuring him to "put on a smile," "snap out of it," or "pull yourself together." Such remarks imply that depression is willful. Pep talks actually tell depressed people that their feelings are wrong or not important and that you really are not listening. Pat answers tell people that things are really simple if they would only try. **Depression is not simple.**

Avoid statements like "Look at all you have. You can still. . . ." "You've had a good life. Count your blessings," "You have everything to live for," "You are so much better off than . . .," or "Don't worry. It'll all work out." Such statements do not communicate caring or that you understand; rather, they smother the person's efforts to talk things out.

BUILD A SUPPORTIVE ENVIRONMENT

Support from family and friends is critical. It helps keep the person from giving up or withdrawing further. A supportive environment is one in which others provide help when needed but avoid increasing the person's feelings of helplessness by doing everything for him.

People often find it difficult to be around a person who is sad, negative, or complaining. You may have to educate family and friends about depression and the person's feelings and needs. Upbeat, positive people who understand depression are particularly helpful.

Set up a system of calling and visiting on a regular basis. Spending focused time with the person can show genuine caring and attention. Scheduling special time with the person, rather than just dropping in, gives him something to look forward to.

Maintain support during and after treatment. Your continuing encouragement will support the efforts of the mental health professional. Even when therapy has ended, your support is still important as the person begins to use his newly acquired coping skills.

Practical help, such as transportation to a clinic or assistance with bills, may help speed the person's recovery. Or you could change a situation contributing to the depression. One daughter said, *"What a difference it made when we moved Mom down to a first floor apartment. She had become isolated, then depressed, after a fall down the stairs. Being on the first floor removed her fear and lifted the depression."*

STRUCTURE ACTIVITY

Depression responds to structure and physical activity. If you can get depressed people involved in doing things, they generally begin to feel better. Exercise, such as walking, can make a difference, particularly for the mildly or moderately depressed. However, you may have trouble getting a depressed person motivated.

A depressed person tends to feel like a failure. It's important for him to experience success, to do something well. Try to find activities that reinforce pleasant events and

build a sense of self-worth and adequacy. Point out his strengths in the process. You can help the person to succeed by assisting him to set small, attainable goals that have immediate results.

GIVE THE PERSON CONTROL

Encourage as much control and decision-making as the person can handle, but don't overwhelm him with decisions. Taking away power unnecessarily only reinforces a depressed person's feelings of inadequacy. Provide choices, but don't push or intrude more than necessary. Respect his autonomy. Because many depressed people have difficulty with decision-making, you need to maintain a delicate balance.

LEARN ABOUT MEDICATIONS

Be aware of any medications the person may be taking that could contribute to depression. If he is being treated for depression with an antidepressant medication, know the therapeutic and side effects, any precautions to follow, and what you can expect so you can quickly spot any problems. Be aware of how antidepressants interact with other medications he may be taking.

BE ALERT TO SIGNS OF SUICIDE

Every depressed person is vulnerable to the risk of suicide, even someone you think would never take his life. Therefore, it's important to be alert to potential signs of suicide and to know what to do if you suspect your older family member or friend may be contemplating taking his or her life.

BE WATCHFUL AT HOLIDAYS

Holidays and anniversaries can be particularly difficult for a depressed person. A past loss linked to the day may seem more poignant. Or the joyousness of a holiday like the Christmas season may serve only to deepen, perhaps by contrast, feelings of sadness or aloneness. Be especially watchful of a depressed person at these times.



TREATMENTS FOR DEPRESSION

MEDICATION THERAPY

PSYCHOTHERAPY

ELECTROCONVULSIVE THERAPY

The earlier a depressed person receives help, the sooner the symptoms will be alleviated and the quicker the recovery.

When depressed people who suffer from a medical problem are treated for both conditions, improvement in their physical health and overall well-being is better than for people who are treated for the medical problem alone. Treatment of the depression also can increase a person's will and capacity to cope with an ongoing medical problem.

Although several treatments are available, the most appropriate treatment will depend on the cause and severity of the depression, the availability and practicality of various treatments, and the person's medical condition. There are three basic types of treatment: medication therapy, psychotherapy, and electroconvulsive therapy. Antidepressant medication and psychotherapy together are often more effective than either treatment alone. Psychotherapy not only enables the person to feel understood and supported, but also increases her willingness to take medication.

Finding the right treatment can take time. No two people are alike in their response to treatment. A treatment should be evaluated regularly so that appropriate continuation and/or changes can be made.

MEDICATION THERAPY

Antidepressant medications are especially effective in treating the symptoms of severe depression: lack of pleasure, sleep and appetite problems, and loss of energy. They alleviate a person's depression by bringing brain chemicals involved in depression back into balance.

Most antidepressant medications fall into

three major categories: tricyclic antidepressants, monoamine oxidase (MAO) inhibitors, and lithium. A person's behavior and patterns may suggest a lack of certain brain chemicals and the use of a particular type of medication:

- **Tricyclic medications** are the major weapon against depression.
- **MAO inhibitor medication** is more likely to be effective with depressed people who are highly anxious, express fears and phobias, and haven't improved with a tricyclic antidepressant.
- **Lithium** is particularly effective for bipolar disorders. It lowers the euphoric highs and alleviates the depressive phase. It's also effective with some forms of recurrent major depression.

Some people, particularly those with recurring forms of depression, need ongoing medication to prevent or alleviate further episodes, much as the diabetic requires insulin. For others, a short period of drug therapy is adequate. Because many older people metabolize and excrete drugs more slowly than younger adults, they may require lower initial and maintenance doses. Usually it takes an older person longer to respond to an antidepressant medication. It may take 2 to 6 weeks before the antidepressant takes maximum effect.

Sometimes people will stop taking a medication when they begin feeling better, thinking the medication has done its job. This can cause a recurrence of the depression in a few days. People are frequently maintained on an antidepressant medication for several months or longer after improvement to help prevent relapses.

Antidepressant medications must be used with caution because they produce side effects, including dry mouth, constipation, urinary retention, blurred vision, drowsiness, or dizziness or faintness when moving to sit or stand up. Even a mild side effect like dry mouth should be given careful attention because it can make someone resist taking medication.



Anyone taking an MAO inhibitor medication must comply with a special tyramine-free diet. MAO inhibitor medications can react with tyramine-containing foods (for example, cheese, wine, and pickles) and force blood pressure to dangerously high levels. Ask the doctor or pharmacist for a list of foods that should not be eaten in combination with an MAO inhibitor medication.

PSYCHOTHERAPY

Psychotherapy, a form of counseling, is usually used to treat mild to moderate depression, but also can relieve severe depression. It works especially well with depressive symptoms such as low self-esteem and problems with relationships. Medication may bring a person sufficiently out of a depression to face her problems, and psychotherapy can then help her develop better coping responses. Psychotherapy helps people examine the underlying causes of depression and develop skills to manage stressful situations.

Age is not a determining factor in the success of psychotherapy. Older people respond well to psychotherapy; however it may not be practical for those who have a significant hearing loss or are memory-impaired.

The three major therapies, which may be used singly or together, are cognitive therapy, behavioral therapy, and interpersonal therapy:

- **Cognitive therapy** helps people change negative thinking. It is based on the premise that a person's mood is determined by the way she interprets an event rather than the event itself. Depressed people tend to view themselves, their environment, and their future negatively. Cognitive therapy helps them monitor their thoughts, identify negative thought patterns that increase their vulnerability to depression, and restructure their thinking in positive ways.
- **Behavioral therapy** emphasizes the importance of daily experiences and behavior. Depression occurs when a person experiences several unpleasant events or too few pleasant events in his life. The goal is to increase the positive events. The therapist guides the person to develop skills or access resources to make this possible. The "pleasant events" are determined individually.
- **Interpersonal therapy** focuses on relationship problems and role conflicts that contribute to the development of the depression.

Therapy addresses the person's way of relating to significant people in her life and helps her change negative patterns and develop effective communication and relationship skills.

ELECTROCONVULSIVE THERAPY

Although many people have difficulty accepting the idea of electroconvulsive therapy (ECT), it has saved the lives of older people who otherwise would have starved to death or committed suicide. This therapy may be considered for situations where a person is severely depressed and dangerously suicidal, when no other treatment has worked, or when the person cannot take antidepressant medications because of serious side effects or a medical problem contraindicates their use.

With ECT, a brief pulse of electricity is passed between electrodes on a person's scalp. A series of treatments are given over several days in a hospital, producing changes in brain function that can quickly bring a person out of a deep depression. Modern methods have reduced the risks of ECT. The major side effects are some mild memory loss and confusion for a short time after each treatment.



HANDLING SPECIAL PROBLEMS

WHAT TO DO IF THE PERSON DENIES BEING DEPRESSED
HELPING FROM A DISTANCE
IDENTIFYING AND RESPONDING TO A SUICIDAL PERSON

WHAT TO DO IF THE PERSON DENIES BEING DEPRESSED

You may see many signs of depression, yet your relative or friend may firmly deny it, blame the symptoms on stress or physical illness, and become angry that you would even think of her as being depressed. She may resist any help. There are no easy ways to deal with resistance; however here are some ideas to help reduce the tension:

- **Visit a mental health professional for yourself.** The therapist will give you assistance in problem-solving, information about how to approach the person, and help you work through your feelings about the person.
- **Identify someone the person trusts.** Enlist the help of anyone who has leverage and influence with the depressed person: her physician, pastor, neighbor, friend, or another family member. Many older people are more likely to accept treatment by a mental health professional if it is prescribed by their own medical doctor.
- **Concentrate on depression as a medical illness.** The physical aspects of depression may be more acceptable to the person than "mental" issues. Therefore, focus on the physical symptoms—problems with sleep, appetite, and fatigue. Anyway, evaluation of a depressed person should always include a thorough physical examination.

Explaining that depression is a medical condition and is often caused by illness, medications, or biochemical factors may relieve the older person of a feeling of shame and make evaluation and treatment more acceptable.

- **Encourage the person to get a medical check-up.** You can help by being willing to go first to see the doctor or go with the older person. But, once you are in the doctor's office, respect the person's autonomy by giving her private time with the doctor.
- **Focus on what the person acknowledges as a problem.** Ask the person what she sees as the problem and address this concern rather than the depression itself.
- **In talking with the person, use "I" rather than "you" statements.** With "I" messages, you speak about your feelings and identify the specific behavior changes you have observed. For example, say *"I know you feel that you're fine, but I am concerned because you seem to be tired most of the time. I'd like you to see your doctor to reassure me that you're okay,"* or *"I am worried about you because you have stopped going to the senior center and to church."*

"You" statements sound dictatorial and tend to create defensiveness and resistance. "You" messages are usually orders or commands, like *"You are depressed and you must quit denying it, and go to the doctor,"* or statements that lay blame on the person, like *"You brought this all on yourself."* Sometimes these remarks give solutions or deny the person's feelings: *"If you'd do....., then you wouldn't be depressed,"* or *"You shouldn't feel depressed. You have so much to live for."*

Sometimes it's necessary to wait for a crisis before the person recognizes the depression and the need for help. Be patient and don't give up.

HELPING FROM A DISTANCE

When you are separated geographically from the person who is depressed, it becomes more of a challenge to help. The following strategies may make the task less complicated:

- **Learn about resources.** Use the telephone to find resources in the older person's community such as a mental health center, the

person's doctor, a physician specializing in geriatrics, the area agency on aging, the local senior citizen's center, or an outreach worker to make a home visit and "bridge" the older person to a mental health specialist. Use these resources for both information and referral.

Encourage the older person to follow up on a specific contact you have made, then check her response and progress by telephone. Before you talk with her physician, get the older person's permission. This encourages her sense of control. Sometimes, however, a person will not give permission. If you ask for it and are told "no," another approach is to tell the person, using an "I" statement, that because of your concern and worry you plan to call her physician. At least she will know what you're doing.

- **Maintain regular contact.** Make frequent telephone calls and really listen to show you care. At times it can be difficult to listen to negative or pessimistic talk, but it's important to encourage communication. Send letters, audio and videotapes, family photos, and other surprises. They help the person feel loved.
- **Find a local support person.** Seek out a person in the community you can trust to monitor the well-being of your family member or friend. Ask the support person to provide you with accurate information about the depressed person's condition and progress. Be willing to pay for this help if you need to.

IDENTIFYING AND RESPONDING TO A SUICIDAL PERSON

Factors that put a depressed older person at high risk for suicide are:

- Severe personal loss, such as health or a significant person
- Feelings of hopelessness and helplessness
- Living in isolation
- Prior suicide attempt
- Alcohol or drug abuse
- Detailed suicide plan, including the means,

- time, place, and method
- A readily available lethal weapon

The clues to suicidal intent are generally more subtle with older people than with younger age groups. The following are common warning signs that a depressed person may be contemplating suicide:

- **A sudden upswing in mood.** A sudden improvement in mood may occur because the depressed person has reached a decision to end her life and may have formulated a plan to do so.
- **Talking about suicide.** It's less common for older people to talk directly about suicide, but when they do, listen and take action. Verbal clues, however, are likely to be more indirect, for example:
 - *You won't have to worry about me much longer.*
 - *Here, take these things. I won't need them anymore.*
 - *There's just nothing to live for.*
 - *I need to tie up loose ends.*
 - *My time has come.*
- **Feeling hopeless and helpless.** A person who expresses a sense of worthlessness, helplessness, and hopelessness through words or actions will often begin to think of suicide as a way out of the situation.
- **Unusual behavior.** A sudden or dramatic change in behavior that is not characteristic of the person should be treated as a warning flag for suicide.

The following are examples of actions that may indicate suicidal intent:

- He suddenly writes a will and puts personal affairs in order whereas previously he resisted doing so.
- She stockpiles medications or makes sudden requests for sleeping pills.
- He shows new interest or disinterest in church and religion.

- She has been active in the community but suddenly resigns from all organizations.
- He gives away important possessions.
- She has always been known as a "penny pincher" but she gives away large sums of money.
- He sells his home and other possessions without plans for replacement.
- She displays uncharacteristic acts of affection; makes amends for things that have happened in the past.
- He increases his use of alcohol.
- She is preoccupied with death.

A time to be particularly vigilant is when a person is coming out of a deep depression. This is a time of suicide. Earlier the person may have felt suicidal but was too paralyzed to act on these feelings. Now, she may have the energy to commit suicide.

The three most important actions to take to prevent suicide are to listen, ask questions, and get professional help:

- **Listen.** Listening is what suicide prevention is all about. Be aware of both obvious and subtle expressions of suicidal intent and take these expressions seriously. Never ignore remarks about suicide. Most important is to be accepting, non-judgmental, and supportive. Encourage the older person to confide in you.
- **Ask questions.** You need to ask questions to assess the risk of suicide. Asking questions about suicide will not give a person the idea to take her life. In fact, asking questions often provides the opportunity for the person to express her emotions, which if not expressed might prove fatal.

You can ask general questions such as "*How is your life going?*" or specific ones like "*Have you considered harming yourself?*" "*Have you thought about ending your life?*" or "*Are you thinking about suicide?*" Don't be afraid to say "suicide"; the mere mention of the word will not create a desire to act it out.

If the person denies that she is wanting to die, the potential for suicide is probably low unless the person is an alcoholic, drug abuser, or psychotic (a mental disorder in which the person has irrational beliefs, is extremely impulsive, and sense of reality is impaired.) If the person hedges (*"Who knows?"*), responds with self-accusations (*"I'm not fit to live"*), or admits to having suicidal thoughts, the potential for suicide is high. Immediately ask these questions:

- How would you take your life?
- Do you have the means available?
- When would you do it?

Questions about specifics of the plan are important. The person who has a plan and the method available is at greatest risk.

- **Get professional help.** If there is a risk of suicide or if you are uncertain about the intentions, get professional help immediately. At this point, the decision to get help may have to be taken from the older person. You must realize that you may have to discuss that forced decision with the person at a later time. Often, however, the person is relieved, not angry, about the decision.

The resources listed below will provide help to the suicidal person. Emergency services are also available in many communities that enable you to get immediate intervention assistance.

Crisis lines and organizations. The volunteers who staff these services receive special training to handle potential suicides and can assist you in getting help. Keep their telephone number where it is easy to find in case of an emergency.

Mental health clinics. These clinics

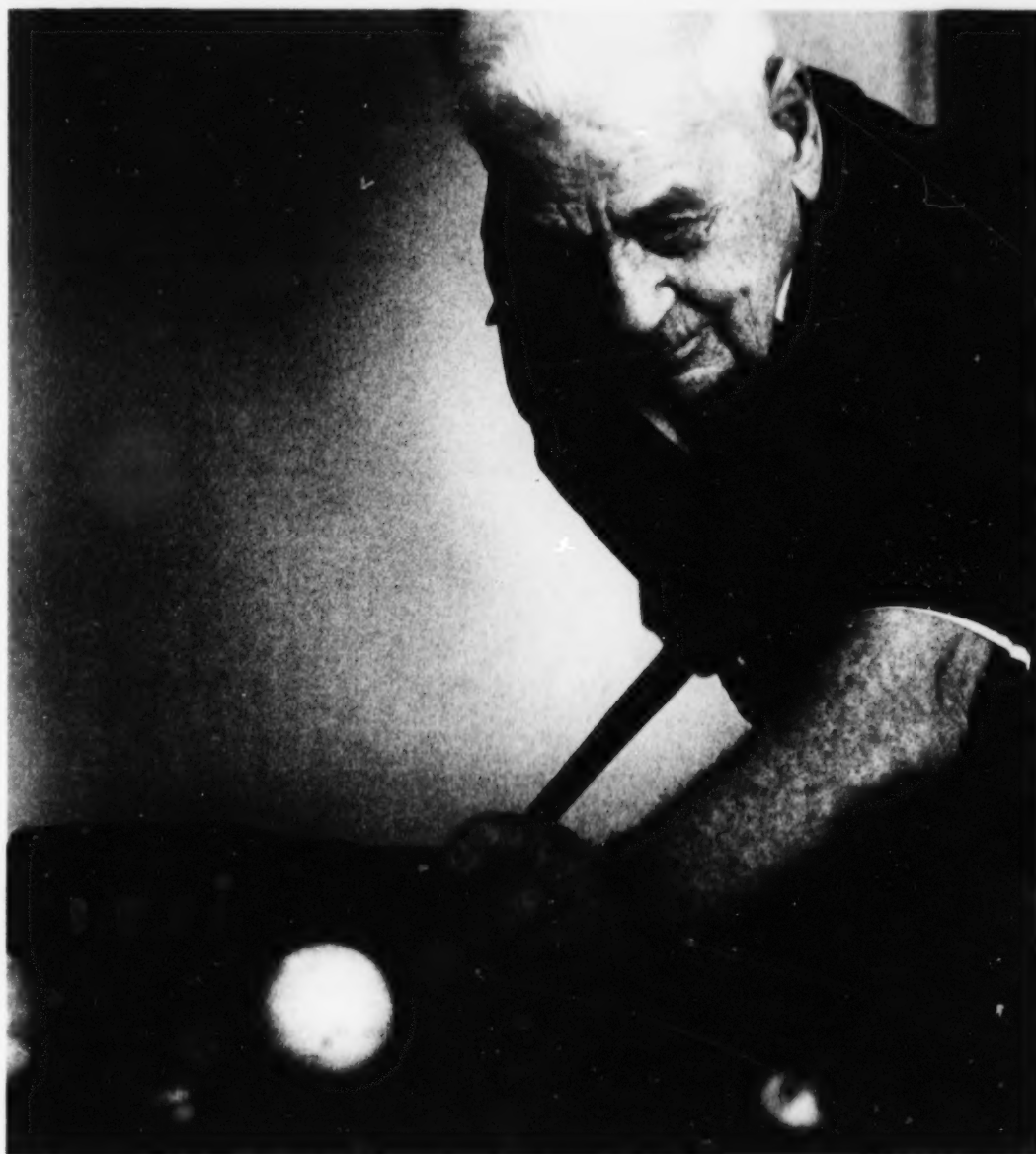
will give immediate attention to suicide threats, whether or not the depressed person is already a client. Most of the mental health clinics have a 24-hour telephone number that you can call in case of an after-hours emergency.

Hospital emergency room. A person who threatens or attempts suicide will receive immediate care in most hospital emergency rooms. Many hospitals have staff available 24 hours a day as part of the inpatient mental health unit. If you cannot get the person into an automobile and to the hospital, call an ambulance.

Police or other emergency service agency. If other resources are not available or you cannot decide what to do, call 911 (or the emergency number in your area) or your local police. You will get assistance in deciding what to do, and help in dealing with the immediate crisis. To intervene with the high-risk person:

- Act decisively.
- Remove the method or weapon.
- Summon help.
- Remain with the person. Do not leave a suicidal person alone.

If the person is not at high risk for suicide, keep monitoring her. Reapproach with questions about suicide if her mood or activity level deteriorates further or suddenly shows an upswing. Keep in frequent contact at least by telephone. If possible, arrange to have someone visit or have her see someone daily or every other day. Try to keep the person away from alcohol. The combination of alcohol and depression places a person at higher risk for suicide.



MYTHS AND FACTS ABOUT DEPRESSION AND SUICIDE

MYTH: Depression is a normal part of aging.

FACT: To be old is not to be depressed. An attitude of "I'd be depressed too if I were old" is a the major barrier to helping a depressed older person. Depression should not be accepted as inevitable in later life.

MYTH: Older people cannot benefit from therapy.

FACT: Depression is treatable at any age. Older people also respond well to short-term psychotherapy.

MYTH: People who are depressed either lack willpower, are psychologically weak, or are "putting on an act."

FACT: Depression is neither an act nor a failure of willpower. It's as real as a heart attack is real. Depression is an illness involving genetic, biological, and environmental factors.

MYTH: People could control their depression if they just had the right attitude.

FACT: The causes of depression are complex. However, a depression is not a condition people can simply will or wish away or "pull themselves together" and

get better. While some people can manage their depression through self-help, others need professional assistance.

MYTH: People who talk about suicide seldom take their lives.

FACT: A person who talks about suicide is at high risk of doing so. Suicidal statements or acts should be taken seriously.

MYTH: Asking a person if he or she has thought about suicide increases the risk that the person will attempt suicide.

FACT: Inquiring about suicidal thoughts in depressed people does not increase the risk. In fact, by asking you are likely to save a life. Many people who have thought about suicide are relieved when asked.

MYTH: Older people who attempt suicide usually do so only to gain attention or to manipulate family members.

FACT: Older people seldom attempt suicide as a means to get attention or as a cry for help. Depression underlies up to two-thirds of suicides in the elderly. Most suicide attempts made by older people are well planned and usually successful.

A FINAL NOTE

Depression is one of the most treatable emotional disorders. Resources are available to help older people move out of their depression and back toward a happier life. Your job is to locate and use the assistance available to you. You can help manage the depression, but remember that you are not responsible for the cure.

You also may need to accept that no matter how much you might want to, you cannot replace the losses or undo the changes in your friend's or relative's life, nor "make him happy." You need to be realistic about what you can do and your own personal limits.

***"Healing the emotions
is all too often viewed as a
sign of weakness, yet we don't
consider it weak to go to a doctor
when we experience physical pain.
Just as it's okay to seek help in
healing our bodies, we (must)
seek help in healing
our minds."***

R.D. COLEN
HEALTH, NOVEMBER, 1988

FOR FURTHER READING

EXTENSION SERVICE PUBLICATIONS

The following publications are available from Publications Orders, Agricultural Communications, Oregon State University, Administrative Services A422, Corvallis, OR 97331-2119. We offer discounts on orders of 100 or more copies of a single title. For price quotes, please call (503) 737-2513.

Aging Parents: Helping When Health Fails by V.L. Schmall and L. Isbell. Pacific Northwest Extension publication PNW 246, Oregon State University, Corvallis, 1984. Reprinted 1993. Single copy 50¢

Alcohol Problems in Later Life by V.L. Schmall, C.L. Gobeli, and R.E. Stiehl. Pacific Northwest Extension publication PNW 342, Oregon State University, Corvallis, Oregon, 1989. Reprinted 1993. Single copy \$1.00

Coping with Caregiving: How to Manage Stress When Caring for Elderly Relatives by V.L. Schmall and R. Stiehl. Pacific Northwest Extension publication PNW 315, Oregon State University, Corvallis, 1987. Reprinted 1993. Single copy \$1.00

Families and Aging: A Guide to Legal Concerns by V.L. Schmall, T. Nay and M. Weinstein. Oregon State University Extension publication EC 1221, Corvallis, 1988. Single copy \$1.25

Financing Health Care in Later Life by V.L. Schmall and R. Stiehl. Pacific Northwest Extension publication PNW 345, Oregon State University, Corvallis, 1989. Single copy \$1.00

Sensory Changes in Later Life by V.L. Schmall. Pacific Northwest Extension publication PNW 196, Oregon State University, Corvallis, 1980. Reprinted 1993. Single copy \$1.00

Helping Memory-Impaired Elders: A Guide for Caregivers by V.L. Schmall and M. Cleland. Pacific Northwest Extension publication PNW 314, Oregon State University, Corvallis, 1987. Reprinted 1993. Single copy \$1.00

Helping Your Older Family Member Handle Finances by V.L. Schmall and T. Nay. Pacific Northwest Extension publication PNW 344, Oregon State University, Corvallis, 1989. Reprinted 1993. Single copy 50¢

Living Arrangements in Later Life by V.L. Schmall and R. Stiehl. Pacific Northwest Extension publication 318, Oregon State University, Corvallis, 1987. Single copy \$1.00

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